AAG
Australian Association of Gerontology

To improve the experience of ageing through CONNECTING RESEARCH, POLICY and PRACTICE

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Description of the Submitting Organisation

Since 1964, the Australian Association of Gerontology (AAG) has been Australia's peak national body linking researchers, educators, policymakers, practitioners, and other experts engaged in ageing issues. AAG's purpose is to improve the experience of ageing through connecting research, policy and practice. Its principles are to be evidence informed, multi-disciplinary and holistic, independent, collaborative and fair. AAG has a growing membership of over 1,300 professionals working across every State and Territory in Australia representing all sectors and disciplines in ageing including research, policy, education, aged care, health and allied health, and consumer advocacy.

AAG is a national organisation with broad reach across an established network of collaborators and experts. In addition, AAG is the executive office of the International Association of Gerontology and Geriatrics Asia/Oceania Region and the International Longevity Centre (ILC) Australia, which is a member of the ILC Global Alliance.

AAG's approach to evidence-based policy and practice incorporates all types of evidence, namely: research evidence, professional knowledge and expertise, the full diversity of older people's needs and wishes, and the policy environment. We are funded to undertake this work in part by a grant from the Dementia and Aged Care Services (DACS) fund. The aim is to support Australian governments, professionals, and providers to deliver evidence-based policy and services to meet the needs of all older Australians.

IHACPA Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024-2025 questionnaire.

Q14. What, if any, changes do you suggest re the residential aged care pricing principles?

AAG welcomes the pricing principles, as they reflect the factors that contribute to the delivery of quality and safe aged care services for older Australians.

Specific considerations:

Quality care: As it is currently presented, this principle fails to reflect the level of chronicity and clinical complexity of aged care residents. The Resource Utilisation and Classification Study (RUCS)[1] clearly demonstrated the high level of care needs of residents: only 15% were independently mobile, one in two (50%) required mobility assistance, and over a third (35%) were not mobile. The majority of residents (> 80%) need help with personal care and activities of daily living, and significant numbers had cognitive and mental health needs which impacted on their ability to communicate, interact with others and participate in meaningful activities.[2] In general, staffing levels are inadequate to meet the clinical and care needs of residents, particularly in terms of nursing and allied health.[3]

Suggested alternative wording: Funding should support the delivery of safe, quality care that meets the clinical, cognitive and functional needs and personal wellbeing of residents; supports continuous improvement and meets the Aged Care Quality Standards, as a minimum; and, deliver outcomes that align with professional and clinical standards as well as community expectations.

Fostering care innovation and Promoting Value: The term 'innovation' is used a lot in aged care with the assumption that it will benefit residents and staff. Any promotion of innovation should ensure that it is evidence-based (evaluated), ethical and demonstrates improved value and quality of care for the resident as well as staff.

Q16. What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes?

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[1] Eagar, Kathy, et al. "AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6." (2019).

[2] Eagar, Kathy, Anita Westera, and Conrad Kobel. "Australian residential aged care is understaffed." Med J Aust 212.11 (2020): 507-8.

[3] Eagar, Kathy, et al. "How Australian residential aged care staffing levels compare with international and national benchmarks." (2019).

There are many in the sector who advocate for additional classification for people with cognitive and/or mental health needs, due to the additional costs associated with 'changed behaviours' – also referred to as behavioural and psychological symptoms of dementia (BPSD). The Commonwealth government currently funds 'specialist' dementia services such as the Severe Behaviour Response Team (SBRT) and the Specialist Dementia Care Program (SDCU) units. The independent evaluation of the SBRT found that the changed behaviours of clients were predominantly due to the resident being in **pain** (66% of clients), **environmental** factors (58%), **staff** insufficiently trained in dementia (41%) or end of life care (11%), and **lack of personalisation** in care practices (40%).[4] These are NOT factors related to the resident; rather, they are system and structural factors that preclude quality care outcomes for residents. Introducing a separate classification for this resident cohort would, effectively, 'reward' those aged care homes that fail to introduce appropriate care models, environments and with poor staffing practices. Instead, costs of providing quality care must be adequately reflected in the pricing framework.

Q17. Are there other legitimate or unavoidable costs associated with a permanent resident's stage of entry? For example, entry into or departure from a service? (5000 characters)

On entry to permanent residential care, the care needs of the resident are high. While entry payments to service providers are welcome, they are insufficient to cover the costs of care that is actually required – both from clinical and essential non clinical staff.

The admission transition process can run for 28 days and includes a whole of facility approach. Input predominantly comes from nursing staff to cover assessment, medication charting and care planning. In addition, other tasks include documenting the resident's next of kin, powers of attorney, planning from the Administration team, spiritual care assessments, cultural needs care assessments, life story from the lifestyle and enrichment and chaplaincy teams, planning for dietary requirements from the catering team, phone consultations with families and social workers (including assisting with Services Australia assessments) on the transition process into residential care. These all represent important elements of quality care but are not covered under the definition of clinical care.

It takes time to get to know a new resident and there are many unpredictable and unknown elements – such as whether a resident is a flight risk (especially prevalent in specialised service provision for homeless cohorts, or residents with experiences of institutional trauma), or likely to exhibit self-harm, violent or other behavioural disturbances. In these instances, staff spend time conducting welfare checks and additional check-ins with the resident, writing Serious Incident Response Scheme reports, or bringing in expert behavioural supports or referral to a geriatrician. Family liaison can be required too where there is conflict or dispute, or where the resident is unhappy about their transition into permanent residential care. Again, these are not covered under payments for clinical care and are worn by the service provider. Residents with a homeless background might have experienced trauma or negative interactions in the past, leading to trust issues. Building rapport and trust is essential for providing effective care, and this process requires extended and often intensive time to develop.

Increasing the entry payments per resident would ensure that providers are able to fully address resident needs (and avoid the need for additional classification for BPSD as outlined in our response to Q14).

On exit from care there can be a range of circumstances that are not well covered, or not covered at all under the current AN-ACC funding. Time taken to prepare handover paperwork to another facility is not covered. For providers with residents with a background of homelessness there can be frequent turnover with residents opting to transfer to another, cheaper option (often with less care included). Providers also face the cost of repairing damage to rooms and costs of removing belongings left behind where the former resident has no financial capacity to pay for these.

When a resident dies at a facility, there can be additional work place on the staff where there is no family (or conflict within family) to step in and manage the next-of-kin work, liaising with the State Trustees office, and holding and managing any refundable deposits.

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[4] Westera A, Fildes D, Gordon R, Bird S, Duncan C, Samsa P and Grootemaat P (2017) Severe Behaviour Response Teams (SBRT} Evaluation: Final Report, Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong. https://agedcare.royalcommission.gov.au/system/files/2020-06/CTH.0001.1000.5761.pdf

Again, there are essential, non-clinical elements of care that are not covered under the pricing framework that need to be addressed. Consideration for additional and top-up payments to cover unpredictable and unexpected events and associated costs would be welcome.

Q18. Are there other legitimate or unavoidable costs associated with a respite resident's stage of entry? What evidence is there to support your answer? (5000 characters)

The time and associated costs for admitting a respite resident are the same as for a permanent resident, as outlined above in Q17.

However, with respite admissions that same amount of time and care work may be compressed into a shorter time frame for shorter respite stays. In addition, the resident then needs to have their care plans provided during handover on transition to home or to another residential facility, or hospital.
Unlike entry to permanent residential care, there is no admission payment for admitting a respite resident, yet the care work entailed is the same.
In addition, the payment categories applicable to respite care cover three categories, ranging from low to high care needs. However, the higher care associated with respite care is not paid at the same level as in permanent care, despite the care needs being equivalent for the resident (regardless of whether they are a respite or a permanent resident). These cost disparities also serve as a deterrent to providers taking on residents with shorter respite stays and with higher care needs.

Q19. What, if any, considerations should IHACPA seek to review in its indexation methodology for its residential aged care pricing advice?

As the Royal Commission clearly demonstrated, funding for the residential aged care sector has been deliberately constrained for over two decades, commencing with the explicit agenda of the Howard Government in 1997[5] and continuing in the years since.[6] There is clearly an argument for indexation to be above and beyond CPI for at least several years in order to address the immediate funding shortfall experienced by providers which, in turn, is compromising the provision of safe and quality care for residents.

Q20. What, if any, additional cost variations are associated with the provision of care to residents who require specialised services? What evidence is there to support this? (5000 characters)

Residents requiring specialised services do qualify for additional payments to address what are termed confounding factors, however, this is often insufficient. For example, these payments do not cover the cost of engaging wound specialists and wound dressings, which are common for residents with history of homelessness.

Another example includes the needs of bariatric residents, who require turning every four hours to for pressure area care. This can take up to 4 staff for turning. Also, a specialist bed can be required to support the weight of the resident, and to facilitate bed and linen turning, however, these specialist beds cost approximately $30,000.

In these examples both a lump sum payment to address the need for specialist equipment, and additional payments are needed to address the costs of providing specialised care. We note that these additional payments should apply to circumstances where residents have additional requirements (such as equipment or specialist services). These additions are different in nature (characteristics of the resident) to the call made by some in the sector who argue extra funding is needed to support residents experiencing changed behaviours. Also, see comments in response to **Question 16**, refuting sector arguments for adjustments/variations to meet the needs of people living with dementia and/or mental illness.

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[5] Cabinet Memorandum JH97/0158 - Residential aged care - long term outlays and issues for funding structures - Decision JH97/0158/CAB https://agedcare.royalcommission.gov.au/sites/default/files/2020-10/RCD.9999.0539.0001.pdf

[6] Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Canberra. p. XXXV Vol 1

Q25. Other comments (5000 characters)

Reassessments can be a slow process, sometimes taking up to 1 month, and do not include back dated payments (even if the resident is approved). If a request for reassessment is submitted on a Friday nothing happens over a weekend, which impacts on residents who are receiving end of life care.

In the example of a request for assessment for palliative care, the resident sometimes dies before the assessment is approved, and palliative care is provided but then the provider does not receive the related payments. Realtime assessments conducted by independent assessors are needed to address these concerns.

We acknowledge that the introduction of the Palliative Aged Care Outcomes Program (PACOP) supports earlier identification of residents approaching end of life and therefore reduce the need for quick turnaround in reassessments; however, the program is in its early stages and not fully implemented within all aged care homes nationally.